Federal Office of Rural Health Policy

Transforming Clinical Practice Initiative Webinar

April 21, 2016
2:00 – 3:00 pm EDT
Better Care, Smarter Spending, Healthier People

**Focus Areas**

- **Incentives**
  - Promote value-based payment systems
    - Test new alternative payment models
    - Increase linkage of Medicaid, Medicare FFS, and other payments to value
  - Bring proven payment models to scale

- **Care Delivery**
  - Encourage the integration and coordination of services
  - Improve population health
  - Promote patient engagement through shared decision making

- **Information**
  - Create transparency on cost and quality information
  - Bring electronic health information to the point of care for meaningful use

Source: Burwell SM. Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.
During January 2015, HHS Announced Goals for Value-Based Payments within the Medicare FFS System

**Medicare Fee-for-Service**

**Goal 1:**
30%

Medicare payments are tied to quality or value through alternative payment models where the provider is accountable for quality and total cost of care by the end of 2016, and 50% by the end of 2018.

**Goal 2:**
85%

Medicare fee-for-service payments are tied to quality or value by the end of 2016, and 90% by the end of 2018.

**Next Steps:**

Testing of new models and expansion of existing models will be critical to reaching incentive goals.

Creation of a Health Care Payment Learning and Action Network to align incentives between public and private sector players.
Overview of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

• Passed House 3/26/2015- Senate 4/14/2015
• Signed into Law 4/16/2015
• Repeals 1997 Sustainable Growth Rate Physician Fee Schedule (PFS) Update
• Changes Medicare PFS Payment
  – Merit-Based Incentive Payment System (MIPS) – quality, cost/resource use, clinical improvement activities, and meaningful use
  – Incentives for participation in Alternative Payment Model (APM)
TCPI Goals and Transformation Phases

Aims Create Systems—Systems Generate Results
Transforming Clinical Practice Goals

1. Support more than 140,000 clinicians in their practice transformation work
2. Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients
3. Reduce unnecessary hospitalizations for 5 million patients
4. Generate $1 to $4 billion in savings to the federal government and commercial payers
5. Sustain efficient care delivery by reducing unnecessary testing and procedures
6. Transition 75% of practices completing the program to participate in Alternative Payment Models
7. Build the evidence base on practice transformation so that effective solutions can be scaled
What are the 5 Phases of TCPI?

1. Set Aims
2. Use Data to Drive Care
3. Achieve Progress on Aims
4. Achieve Benchmark Status
5. Thrive as a Business via Pay for Value Approaches
Transforming Clinical Practice would employ a **three-prong approach** to national technical assistance.

This technical assistance would enable large-scale transformation of more than **140,000 clinicians’ and their practices** to deliver **better care and result in better health outcomes at lower costs.**
Transforming Clinical Practice Initiative: Practice Transformation Networks (PTNs)

- Arizona Health-e Connection
- Baptist Health System, Inc.
- Children's Hospital of Orange County
- Colorado Department of Health Care Policy & Financing
- Community Care of North Carolina, Inc.
- Community Health Center Association of Connecticut, Inc.
- Consortium for Southeastern Hypertension Control
- Health Partners Delmarva, LLC
- Iowa Healthcare Collaborative
- Local Initiative Health Authority of Los Angeles County
- Maine Quality Counts
- Mayo Clinic
- National Council for Behavioral Health
- National Rural Accountable Care Consortium
- New Jersey Innovation Institute
- New Jersey Medical & Health Associates dba CarePoint Health
- New York eHealth Collaborative
- New York University School of Medicine
- Pacific Business Group on Health
- PeaceHealth Ketchikan Medical Center
- Rhode Island Quality Institute
- The Trustees of Indiana University
- Vizient
- University of Massachusetts Medical School
- University of Washington
- Vanderbilt University Medical Center
- VHQC
- VHS Valley Health Systems, LLC
- Washington State Department of Health
Transforming Clinical Practice Initiative: Support & Alignment Networks (SANs)

- American College of Emergency Physicians
- American College of Physicians, Inc.
- American College of Radiology
- American Medical Association
- American Psychiatric Association
- HCD International, Inc.
- National Nursing Centers Consortium
- Network for Regional Healthcare Improvement
- Patient Centered Primary Care Foundation
- The American Board of Family Medicine, Inc.
## TCPI AIMS/Goals

1. Support more than 140,000 clinicians in their practice transformation work.
2. Build the evidence based on practice transformation so that effective solutions can be scaled.
3. Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients.
4. Reduce unnecessary hospitalizations for 5 million patients.
5. Sustain efficient care delivery by reducing unnecessary testing and procedures.
6. Generate $1 to $4 billion in savings to the federal government and commercial payers.
7. Transition 75% of practices completing the program to participate in Alternative Payment Models.

## Primary Drivers

- **Patient and Family-Centered Care Design**
  - 1.1 Patient & family engagement
  - 1.2 Team-based relationships
  - 1.3 Population management
  - 1.4 Practice as a community partner
  - 1.5 Coordinated care delivery
  - 1.6 Organized, evidence based care
  - 1.7 Enhanced Access

- **Continuous, Data-Driven Quality Improvement**
  - 2.1 Engaged and committed leadership
  - 2.2 Quality improvement strategy supporting a culture of quality and safety
  - 2.3 Transparent measurement and monitoring
  - 2.4 Optimal use of HIT

- **Sustainable Business Operations**
  - 3.1 Strategic use of practice revenue
  - 3.2 Staff vitality and joy in work
  - 3.3 Capability to analyze and document value
  - 3.4 Efficiency of operation
The Trustees of Indiana University

- Awardee: The Trustees of Indiana University
- PTN Name: The Great Lakes PTN (GLPTN)
- Three-state coalition of 33 healthcare partners including eight universities, local community and state and regionally based partners.
- The network will train and deploy 52 Quality Improvement Advisors (QIAs) to coach practices with more than 11,500 clinicians in Illinois, Indiana, Kentucky, Ohio and Michigan through the TCPI’s five phases of practice transformation.
- GLPTN is targeting providers in Federally Qualified Health Centers (FQHCs), rural health centers, urban health organizations and community pharmacies.
The National Rural Accountable Care Consortium

• Awardee and PTN Name: National Rural Accountable Care Consortium

• The Consortium has a team of 33 employees who will be working with a total of 7,350 clinicians from 525 practices across the country in all 50 states.

• The Consortium works with Primary Care Providers and specialists who work in the outpatient setting, including all of those on the 2015 CMS List of Eligible Professionals. Their primary focus is on providers working in rural settings, including CAHs, FQHCs, RHCs, and rural fee-for-service providers. The PTN will also include some urban and semi-urban providers who are part of rural referral networks.
TCPI Practice Transformation Networks (PTNs) Contact Information

- [http://www.healthcarecommunities.org/](http://www.healthcarecommunities.org/)
Total Enrollment from PTNs and SANs

Total Enrollment from PTNs & SANs

<table>
<thead>
<tr>
<th>Date</th>
<th>Enrollment</th>
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<tr>
<td>01/12/16</td>
<td>40,722</td>
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<tr>
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<td>39,620</td>
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<tr>
<td>02/16/16</td>
<td>42,680</td>
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<td>03/01/16</td>
<td>50,865</td>
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<td>03/29/16</td>
<td>55,213</td>
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<tr>
<td>04/06/16</td>
<td>70,720</td>
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</table>

SAN's not polled on 03/29/15

Legend:
- Green: Enrollment
- Red: Year 1 Target
Connecting 140,000+ Clinicians and Others in Action!

- Main Community for all participants and stakeholders
- Sub-communities for each PTN/SAN
- Public page for news and results
- Learn what’s new – Announcements
- Manage your time – Event Calendar with registration and reminders
- Share resources and tools/Advanced Search for what you need
- Subscribe to document updates
- Hear/View others’ stories – Media Library
- Get help – Single Solutions Center for all questions/issues
- Connect with others locally and nationally and by topic – Listservs, Blogs and Forums
- Share results and success

And much more – all in one place!
Great Lakes Practice Transformation Network

Malaz Boustani, MD, MPH - Principal Investigator
Nadia Adams, MHA – Network Director
Anya Day, MPH – GLPTN Lead Michigan Region
GLPTN formed as part of the **Transforming Clinical Practices Initiative (TCPI)** to help clinicians advance their practices, lower healthcare costs, and improve the health of patients across the Midwest. We aim to help practices achieve healthier patients, better coordinated care, and greater financial success – at **no cost** to providers.

- One of **29 practice transformation networks** (PTNs) awarded
- **10 support and alignment networks** (SANs) awarded to support PTNs
- Awarded **$46.4 million** of $685 million total

**Lead organizations:**
- Indiana University (primary grant recipient)
- Purdue Healthcare Advisors (Indiana)
- Northwestern University (Illinois)
- Altarum Institute (Michigan)
GLPTN Key Indicators of Success

1. Partner with 11,500 clinicians to transform to value-based care
2. Work with 15% Rural and 34% of medically underserved settings
3. Improve health outcomes for 10 million patients
4. Reduce unnecessary hospitalizations
5. Generate at least $1B in cost savings to payers
6. Reduce unnecessary testing and procedures to improve efficiency
7. Build evidence base to scale effective solutions
GLPTN Key Facts

- 33 healthcare partners
- 7 universities
- $46.4M received
- $1B in cost savings
- Indiana, Michigan, Illinois, Ohio & Kentucky
- 11,500+ clinicians
- 13% Rural
- 10 million+ lives impacted

52 on-site, on-demand Quality Improvement Advisors
Our Transformation Toolkit

We offer a **four-part change package** to help you shape your practice for the future of healthcare delivery and compensation.

- **Implementation Science:** Learn how to identify practice areas that could benefit most from improvement, and those that should get immediate attention.
- **Lean and Six Sigma:** Improve the flow of your workplace, so you can make changes to your processes as soon as you see the need for them.
- **Personalized Population Health:** Help with reporting data for patient groups with certain core conditions so treatments that benefit them become clear.
- **CMS Compliance:** Prepare you to get ready for new performance-based compliance standards, and qualify for incentives under MIPS.
Our Personalized Approach to Transformation

- **Team of professionals** trained in quality improvement, process improvement, clinical informatics and data analytics
- **Complimentary readiness assessment** and realistic **personalized action plan** to identify areas of improvement and help create your roadmap to better outcomes and efficiency
- **Training and implementation support**
- **Regular reporting** detailing your practice’s progress and milestones
- **Lessons learned** from other practices
6 Clinical Quality Focus Areas

- **Medication Management**
  - Controlling high blood pressure
  - Anticoagulation therapy in patients with atrial fibrillation

- **Unnecessary Testing**
  - Advanced diagnostic imaging
  - Esophageal-gastric-duodenoscopy (EGD)
  - Colonoscopy

- **Prevention**
  - Influenza vaccination rates

- **Behavioral Health**
  - Depression screening and follow-up

- **Chronic Disease Management**
  - Diabetes
  - Chronic Obstructive Pulmonary Disorder (COPD)
  - Congestive Heart Failure (CHF)

- **Reducing Preventable Hospitalizations**
What We Offer

- **Choose your improvement priorities**, beyond the core measures
- Learn how to run your practice more efficiently and **generate more revenue**
- Participate in **MOC** and **CME** credits – most of which are free
- On-site, on-demand **Quality Improvement Advisors** (QIAs) support providers through 5 CMS phases of transformation by:
  - Enhance participation in **PQRS**
  - Establish **Chronic Care Management** program and leverage new **Medicare billable care coordination** changes
  - Understand upcoming **MIPS 2019** reimbursement changes
Why join the Great Lakes Practice Transformation Network?
1. Access to CMS and deep federal resources

- We connect you to a broad network of resources to ensure that your practice prospers – all at no cost to you.
- Get access to virtual and face-to-face networks of experts, peers, and QIAs.
- Get access to Healthcare Communities to share lessons learned with other practices.
2. Greater efficiency for higher revenue

We offer technical assistance to help clinicians leverage new financial incentives and reimbursement changes by aligning with:

- Meaningful Use
- Provider Quality Reporting System (PQRS)
- Merit-Based Incentive Payment System (MIPS 2019)
- Quality improvement programs, including Value-based Modifier (VBM)
3. More time seeing patients

- Our personalized QIAs guide your practice to achieve goals you choose so your clinicians can focus on what they do best – providing excellent care to patients.
- QIAs will work with clinicians and staff to integrate new tools and methods with your existing quality improvement initiatives.
- See measurable improvements in patient satisfaction and outcomes.
Thank you!
Questions? Ready to enroll?
Email: info@glptn.org
Website: glptn.org
Apply online: glptn.org/apply-now
Practice Transformation Network (PTN): Getting Ready for Value-Based Payments

The project described was supported by Funding Opportunity Number CMS-1L1-15-003 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HHS or its agencies.
Who is the Consortium?

- The National Rural Accountable Care Consortium is a non-profit organization that supports rural healthcare transformation.
- Formed by rural providers to avoid being left behind.
- Awarded up to $31 million TCPI grant in 2015 to assist 525 rural health systems in preparing for value-based payments.
- The National Rural ACO (sister company) which began operating the first ACO in 2014, operated 6 ACO’s in 2015, and organized 170 systems into 24 ACO’s for 2016.
Green = ACOs
Blue = TCPI
Practice Transformation Network

Establish Your Value-Based Infrastructure at No Cost.

www.NationalRuralConsortium.org
Proprietary & Confidential, Not for Distribution
Set Up Your Billable Care Coordination Service

- Mentor, Train, and Certify your Care Coordinators as Clinical Health Coaches (CHC)
- Implement the necessary IT infrastructure – Lightbeam Health
- Provide a 24/7 nurse advice hotline
- Bill Medicare $42 PMPM
Redesign Your Practice to Better Manage Population Health

• Modify clinic workflow to address care gaps
• Provide data to identify cost-savings opportunities
• Report and improve ambulatory quality scores
• Measure patient satisfaction at the point of care (Tablet)
• Get paid quality bonuses
Preparing to become a Patient-Centered Medical Home (PCMH)

• Establishes team based care
• Lay the foundation to apply for certification as a PCMH.
• The primary PCMH elements are built into our program in a Plan, Do, Study, Act (PDSA) format.
Improved Billing and New/Increased Revenue Streams

• Program activities designed to reduce cost and improve quality.
• Maximize additional population health payments
• Prevent value-based payment penalties
• Improve financial stability of local health systems.
<table>
<thead>
<tr>
<th>Domain</th>
<th>Metric Name</th>
<th>Eligible</th>
<th>Measure Met</th>
<th>Performance</th>
<th>Change</th>
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<tbody>
<tr>
<td>At-Risk Population Coronary Artery Disease</td>
<td>CAD-2 Lipid Control**</td>
<td>11</td>
<td>9</td>
<td>81.82%</td>
<td></td>
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<tr>
<td>At-Risk Population Coronary Artery Disease</td>
<td>CAD-7 ACE or ARB with Diabetes or LVSD</td>
<td>7</td>
<td>5</td>
<td>71.43%</td>
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<tr>
<td>At-Risk Population Coronary Artery Disease</td>
<td>CAD-Composite</td>
<td>11</td>
<td>7</td>
<td>63.64%</td>
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<td>Care Coordination/Patient Safety</td>
<td>CARE-1 Medication Reconciliation**</td>
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<td>2</td>
<td>100.00%</td>
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<tr>
<td>Care Coordination/Patient Safety</td>
<td>CARE-2 Fall Screening</td>
<td>5</td>
<td>1</td>
<td>20.00%</td>
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<tr>
<td>At-Risk Population Depression</td>
<td>Depression remission 12 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-7 Eye Exam</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-13 High Blood Pressure Control**</td>
<td>4</td>
<td>2</td>
<td>50.00%</td>
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<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-14 LDL-C Control in Diabetes</td>
<td>4</td>
<td>2</td>
<td>50.00%</td>
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<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-15 Hemoglobin A1c Control</td>
<td>4</td>
<td>0</td>
<td>0.00%</td>
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<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-16 Daily Aspirin or Antiplatelet with IVD</td>
<td>1</td>
<td>1</td>
<td>100.00%</td>
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<td>At-Risk Population Diabetes</td>
<td>DM-17 Tobacco Non-Use**</td>
<td>4</td>
<td>3</td>
<td>75.00%</td>
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<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-2 HA1c Poor Control**3 (lower score)</td>
<td>4</td>
<td>1</td>
<td>25.00%</td>
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<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-Composite</td>
<td>4</td>
<td>0</td>
<td>0.00%</td>
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<tr>
<td>At-Risk Population Heart Failure</td>
<td>HF-6 Beta-Blocker Therapy for LVSD</td>
<td>5</td>
<td>4</td>
<td>80.00%</td>
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<td>At-Risk Population Hypertension</td>
<td>HTN-2 Controlling High Blood Pressure</td>
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<td>9</td>
<td>60.00%</td>
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<td>9</td>
<td>100.00%</td>
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<tr>
<td>Preventative Health</td>
<td>PREV-05 Breast Screening</td>
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<td>20</td>
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<td>37.50%</td>
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<td>Preventative Health</td>
<td>PREV-06 Colorectal Cancer Screening</td>
<td>36</td>
<td>18</td>
<td>50.00%</td>
<td>32.61%</td>
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<td>Preventative Health</td>
<td>PREV-07 Influenza Immunization</td>
<td>16</td>
<td>3</td>
<td>18.75%</td>
<td>44.89%</td>
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<tr>
<td>Preventative Health</td>
<td>PREV-08 Pneumonia Vaccination</td>
<td>25</td>
<td>9</td>
<td>36.00%</td>
<td>22.82%</td>
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<tr>
<td>Preventative Health</td>
<td>PREV-09 Body Mass Index Screening</td>
<td>21</td>
<td>17</td>
<td>80.95%</td>
<td>-7.04%</td>
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<tr>
<td>Preventative Health</td>
<td>PREV-10 Tobacco Use Screening</td>
<td>20</td>
<td>20</td>
<td>100.00%</td>
<td></td>
</tr>
<tr>
<td>Preventative Health</td>
<td>PREV-11 High Blood Pressure Screening</td>
<td>36</td>
<td>26</td>
<td>72.22%</td>
<td>2.14%</td>
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<tr>
<td>Preventative Health</td>
<td>PREV-12 Clinical Depression Screening</td>
<td>19</td>
<td>3</td>
<td>15.79%</td>
<td>59.21%</td>
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</table>

Grand Total: 2014 = 304, 2015 = 175, Change = 57.57%, 2014 = 243, 2015 = 188, Change = 77.37%
Eligibility

- PQRS-Eligible Professionals
  - PHYSICIANS, PA’s and NP’s
- Critical Access Hospitals (CAHs)
- RHCs, FQHCs
- Rural Fee-for-Service Clinics
- Urban rural network providers

Who are not already part of any Medicare Shared Savings program (MSSP, CPCI, etc.)
Participation Requirements

- Participants must appoint or hire an in-house care coordinator (will bill Medicare for new services)
- Active participation in the program, including attendance at:
  - Training webinars
  - Regional workshops
  - Divisional workshops, and

(Travel for regional & divisional workshops is reimbursed through the grant)
Questions? – Next Steps

Go to [www.nationalruralaco.com](http://www.nationalruralaco.com)

- Click on **Apply Now** to get ready for the future.

OR CONTACT us at:

PTN@NationalRuralACO.com

THANK YOU!
Questions?